outlet is subject to sudden enlargement, it forms the mouth of a funnel through which a large and irregular body (the child) is to be propelled.

Three grades of tears—1. Begins at the fourchette and breaks down the lax tissue; it does not in any way affect the supporting structures of the vaginal outlet, this is, therefore, unimportant as far as the support goes. 2. A tear running up one of the sulci of the vagina, tongue-shaped, into the vagina. This is the result of the head and shoulders of the child tearing up the tissues at the side of the levator ani. The important part of the tear lies within the vagina. This injury, which often escapes notice, should be sought out and treated at once. Bring the patient to the edge of the bed, and get a thorough exposure of the wound. Silk sutures are best, the first one passed must be in the upper angle of the wound; one or two sutures within the vagina will be sufficient, and they must be passed so that the lowest and deepest part of the suture will be nearer the operator and the vaginal outlet than will be the point of entrance or exit; this tucks up the tissue in the proper manner. The common method is apt to leave a pocket or sac in the vagina, and the outlet is not properly supported. The old method also was to pass the sutures on the outer or skin surface first; this gave a good skin perineum, but a great well is left within the vagina for secretions to collect. 3. A degree of tear which involves the integrity of the bowel, the rupture passing through the sphincter and up the recto-vaginal septum to a variable extent and involving a tear of the levator ani fibres. We must close this in two stages—suturing the bowel first, either by continuous or interrupted cat-gut suture, deeply placed. Then pass one or two silk sutures, passing them well back so as to afford good support. Cat-gut is excellent, but will not stand pressure, therefore silk must be used in addition. Then complete the operation by the superficial sutures as described, then the skin sutures. A well-performed immediate operation always succeeds in the absence of puerperal fever. It is always to be preferred; the patient is relieved from the discomfort of a second operation.

There are two important secondary operations where we have to deal with (*a*) a complete tear through the sphincter; (*b*) where we have relaxation of the vaginal outlet. It is difficult to find the ends of the divided sphincter. If the tear be a shallow one, although just through the sphincter, still the ends of the sphincter may be so held together by the tissues in which it lies, and eventually in cicatricial tissue, that there is not incontinence of fæces afterwards. When we have a case in which the sphincter has been torn across, we wish to make the condition as much as possible like the recent tear. This is done by denudation and then suture as in recent tear. The tear may go up one sulcus or both, or up the middle line of the posterior vaginal wall.

The condition known as *relaxation of the vaginal outlet* is the most important of the injuries here. This condition is often not recognised. In this condition we notice that the anus and the vaginal outlet have dropped back. The perineum is frequently deep and the skin perineum, measured with a tape-line, may be found to be extensive; nevertheless the support of the vaginal outlet may be lost. The walls of the vagina may pouch, and we may find a cystocele, or a rectocele, or both. If we place the patient in Sim's position, the absolute lack of support becomes very evident. Palpation also aids us, the skin perineum can sometimes be picked up between the fingers and thumbs and carried forward over the clitoris. The anterior, posterior, and lateral vaginal walls look as if they might afford support, but to the simple touch they yield, showing that they fill up without supporting the vagina. What has become of the loop of muscular fibre which affords support? The fibres of the levator ani are found lying parallel to and alongside the vaginal walls, their transverse continuity severed and their support gone. The characteristic "rolled out" appearance of the relaxed vaginal outlet can be developed by placing the thumbs on either side of the outlet and pushing upwards and backwards. Another test is by introducing the fingers and pulling downwards and outwards, when the cervix uteri can actually be seen under such conditions. The relaxed outlet may sometimes be concealed, such women are under a more or less constant strain, a constant effort to draw up the muscle, and the result often is reflex nervous symptons. Relaxation suspected is developed on putting the patient under an anæsthetic. The hymen in